Legionellosis Questionnaire – Maryland DHMH Supplemental

Patient Name: _____ NEDSS Patient ID: _____

County: _____ NEDSS CAS #: _____

Zip Code: _____ Date of Birth: ____/____/_____ Sex: M / F

Onset Date: ____/____/_____ Date admitted to hospital: ____/____/_____

In the 10 DAYS prior to the onset of your illness -

1) What was your place of employment (name and address)?

   Did you go anywhere offsite for work? If YES, list all.

2) Were you exposed to aerosolized water at your place of employment? If YES, please describe.

3) Did you shop at a grocery store? If YES, list all.

   Did the store(s) have a mister machine for the produce? If YES, list all.

4) Did you shop at a department store, shopping mall, home improvement center (e.g., Wal-Mart, Home Depot, Lowe's)? If YES, list all.

5) Did you attend any conventions or public gatherings (e.g. community event, movie theater, place of worship, etc.)? If YES, list all.

6) Did you have any dental work done? If YES, where?

7) Did you go to a health or fitness club? If YES, list all.

8) Did you go to a car wash to wash your car? If YES list all.

If YES, was it an automatic or self-wash?

9) Did you visit a gas station with a car wash? If YES, list all.

10) Did you visit a water park or an amusement park? If YES, list all.

11) Did you visit a garden center or anywhere they sell plants? If YES, list all.
Were the plants being watered while you were there? If YES, how (watering can, sprayer/mister, etc)?

12) Did you work with potting soil? If YES, what brand and where was it purchased?

13) Have there been any water-related issues at your home or any place you stayed, such as disruption in the water system, water main breaks, or prolonged periods of time where the water system was not used? If YES, when and for how long?

Other possible sources of aerosolized water exposure in past 10 DAYS: (check all that apply)

___ showers (other than home residence)
___ humidifiers
___ wet sauna
___ decorative fountains
___ cooling tower
___ evaporative condenser

Underlying causes/conditions: (check all that apply)

___ smoker If YES, CURRENT or FORMER (circle one)
___ chronic respiratory disease
___ immunosuppressed
